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Health care industry developments - 1998/99; Audit risk alerts

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AUDIT RISK ALERTS

AICPA

AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS

Health Care Industry Developments—1998/99

Complement to AICPA Audit and Accounting Guide
Health Care Organizations

Notice to Readers

This Audit Risk Alert is intended to provide auditors of financial statements of health care organizations with an overview of recent economic, industry, regulatory, and professional developments that may affect the audits they perform. This document has been prepared by the AICPA staff. It has not been approved, disapproved, or otherwise acted on by a senior technical committee of the AICPA.

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The staff of the AICPA is grateful to the members of the Health Care Committee for their contributions to this document.

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In This Year's Alert...

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Health Care Industry Developments—1998/99

Industry and Economic Developments

What are the industry and economic conditions facing health care organizations in the current year?

The demand for health care services continues to trend upward in 1998 due largely to the baby-boom generation. As this population segment ages, driving up the average age of the American people as a whole, and as the number of people with chronic conditions grows, overall health care spending will continue to climb.

Despite increasing demand, however, health care organizations are feeling pressure from the bill-payers—predominantly employers, third-party payers, and the government—for more efficiency in a system with too much capacity and too few productivity improvements. The federal government is aggressively pursuing health care cost savings, in large part to balance the federal budget. More private-market approaches are being adopted, and greater resources are being allocated to the ongoing crackdown on fraud, waste, and abuse in governmental health care programs. The impact on auditors of efforts to uncover fraud in governmental programs is addressed in this Audit Risk Alert, in the Regulatory, Legislative, and Other Developments section, under Governmental Investigations Relating to Fraud and Abuse Violations.

Managed care plans are also feeling pressure for more efficiency, reduced utilization, better quality measures, and increased choice to recipients. In an effort to maintain and grow market share in recent years, managed care plans did not increase premiums sufficiently to cover significant cost increases. As a result, many managed care plans, both regional and national, now find themselves operating at losses and have a need to increase premiums substantially, against significant employer resistance. Further, many state governments, which have shifted to Medicaid managed care, have begun to curtail funding. Consequently, many managed care

plans that rely substantially on Medicaid enrollment are suffering significant operating losses, while others are curtailing Medicaid managed care growth initiatives. Auditors should consider whether such circumstances raise going-concern issues or suggest the presence of fraud risk factors.

Consumers are becoming more demanding for greater responsiveness from health care organizations while also having higher expectations of service. Quality of service is therefore more likely to take the center stage as health care organizations seek a competitive advantage by investing more in the measures and standards of quality. Consumers' desire for greater choice and availability will also grow.

Thus, health care organizations increasingly find themselves caught between the cost-conscious major purchasers of health care services on the one hand, and service-conscious individual consumers on the other. One of the means through which organizations are achieving the dual objectives of cutting health care costs and increasing the quality of services provided is by combining resources. The numbers of independent hospitals and physicians continue to diminish, as most of them join organizations that have greater power to negotiate prices. Undercapitalized physician groups are being forced increasingly to align with hospital systems or physician practice management companies (PPMs) (the exceptions are large multi-specialty groups with a strong primary care physician base). As a result, most industry sectors, including both for-profit and not-for-profit entities, are consolidating. This trend points to continuing concentration in an industry increasingly dominated by large and capital-intensive providers.

The number of mergers and acquisitions announced last year rose by nearly 19 percent, but this was a slower rate than the prior year. That deceleration will likely continue in the near term, as recently acquired health care organizations and facilities are assimilated. Nevertheless, as long as the average hospital is filling just 60 percent of its beds, merger pressure will continue. As health care gradually shifts from more costly settings to home and noninstitutional care, the drive to reduce capacity is also prompting consolidation in nursing homes, assisted-living centers,

providers of home health care, and other lower-cost alternatives to hospital beds. The movement of large, well-capitalized providers into these traditionally fragmented industry segments underlies the consolidation trend. Investor-owned physician management companies, which continue to grow in number, are also choosing to consolidate. A comprehensive discussion of the auditing and accounting issues that arise out of the business combinations is addressed in the AICPA *Audit Risk Alert—1998/99.*

With consolidation comes dramatic change in the structure of an entity. In an effort to create greater cost efficiencies, departments are combined and duplicate functions are eliminated. Auditors should consider the impact of such changes on their client's internal control. Statement on Auditing Standards (SAS) No. 55, *Consideration of Internal Control in a Financial Statement Audit* (AICPA, *Professional Standards*, vol. 1, AU sec. 319), outlines the auditor's responsibilities with regard to considering a client's internal control in planning and performing an audit. In addition, auditors should consider whether management has appropriately accounted for the consolidation. For example, goodwill arising in purchase transactions may be an especially judgmental area and is therefore likely to require close scrutiny. The issue of goodwill as it relates to entities reporting to the Securities and Exchange Commission (SEC) is addressed in the Accounting Issues and Developments section of this Alert.

Competitive forces are strong within the industry and are particularly a threat to smaller, local health care organizations. Many health care enterprises are regional and national, with major players capable of moving into new markets within a very short time frame. Market segments unheard of just a few years ago, such as physician practice management, get major infusions of Wall Street capital and become forces to reckon with overnight. Changes in policy emphasis from Washington create new forms of competition, such as Medicare and Medicaid managed care. Auditors should consider the effect of such competitive forces on their client's ability to continue as a going concern. SAS No. 59, *The Auditor's Consideration of an Entity's Ability to Continue as a Going Concern* (AICPA, *Professional Standards*, vol. 1, AU sec.

341), provides guidance to the auditor in conducting an audit in accordance with generally accepted auditing standards (GAAS) with respect to evaluating whether there is substantial doubt about an entity's ability to continue as a going concern.

In the past, concentrations of credit risks for many health care organizations have generally been confined to the amount of business or receivables outstanding with governmental payers (Medicare and Medicaid). In recent years, however, many governmental payers have turned to private managed care plans for health care services. As a result, governmental payers no longer make up the majority of receivables of some health care organizations. These organizations may now find that a significant amount of their business activity or receivables relies on potentially insolvent organizations, such as managed care plans that are suffering operating losses. In addition, certain managed care plans may have a concentration of significant business activity with major employers of a community, state government, or both through the Medicaid managed care initiatives of that state. In certain states, many Medicaid-reliant managed care plans find themselves operating at significant losses due in large part to reduced state government funding of Medicaid managed care premiums. In such circumstances, auditors should consider whether a health care organization's management has followed the guidance in Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards No. 105, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk* (FASB, *Current Text,* vol. 1, sec. F25), to ensure that appropriate disclosures have been made regarding credit risk concentrations.

Health care organizations are increasingly shifting their attention to the essentials of information technology, placing more emphasis on, and investment in, basic information technology infrastructure. Among the top priorities include the computerization of patient records, and as consumers demand more health care information, doctors, hospitals, and health plans are becoming more active in relaying that information to consumers, especially through the Internet. As a result, auditors of health care organiza-

tions are increasingly likely to be confronted with evaluating evidential matter that may exist only in an electronic format. Traditional source documents are increasingly being replaced by electronic communications between the audit client and its patients and vendors. SAS No. 31,*Evidential Matter* (AICPA, *Professional Standards*, vol. 1, AU sec. 326), provides guidance to auditors who have been engaged to audit the financial statements of an entity that transmits, processes, maintains, or accesses significant information electronically.

Executive Summary—Industry and Economic Developments

- The demand for health care services continues to trend upward; however, health care organizations are feeling pressure from bill payers for more efficiency in a system burdened by excess capacity and minimal productivity improvements.
- To meet consumer demands, health care organizations are striving to cut costs and increase quality by combining resources. Thus, industry mergers and acquisitions continue in the current year, though at a slower rate than previous years.
- Competitive forces within the industry remain strong, and may call into question some entities' ability to continue as a going concern. In such circumstances, auditors should be aware of their responsibilities pursuant to SAS No. 59, *The Auditor's Consideration of an Entity's Ability to Continue as a Going Concern.*
- Health care organizations are increasingly placing more emphasis on, and investment in, basic information technology infrastructure. As such, auditors should be familiar with the guidance set forth in SAS No. 31, *Evidential Matter.*

Regulatory, Legislative, and Other Developments

What significant regulatory and legislative initiatives should auditors of health care organizations be aware of?

Governmental Investigations Relating to Fraud and Abuse Violations

The federal government and many states have aggressively increased enforcement efforts under Medicare and Medicaid antifraud and

abuse legislation. Thus far, those efforts have achieved significant success. For example, in fiscal 1997 alone, the Health and Human Services Office of Inspector General (OIG) reported $1.2 billion in recoveries. As such, these enforcement efforts appear likely to increase during 1998 and beyond.

Laws addressing false claims for payments under a federal health care program (including Medicare and Medicaid) and applications of the civil False Claims Act to such claims are exposing health care organizations to potential civil penalties ranging from $5,000 to $10,000 per false claim and treble damages. A whistleblower statute that rewards private parties for false-claim identification has spurred enforcement activity and increased provider risk. Recent broad interpretations of these statutes by federal enforcement agencies and whistle-blowers are exposing billing violations and unlawful remuneration arrangements to scrutiny and penalty consideration as potential false claims. In addition, the government has recently begun to investigate managed care plans for denying medically necessary care.

Similarly, as a result of recent legislative changes criminalizing false statements made in connection with private health care benefits, fraud against private insurers and self-insured employers can now be more easily prosecuted by government authorities. Meanwhile, private insurers are apparently increasing their own efforts to detect fraudulent activities (including false claims and kickbacks) and recoup related reimbursements, sometimes based on the Racketeer Influenced and Corrupt Organizations (RICO) law.

Although government investigations may focus on a broad range of practices, the OIG has indicated that the following areas are of special concern:

- Assignment of inappropriate Diagnosis-Related Groupings (DRGs), for example, related to pneumonia
- Billing for items and services not rendered, and providing medically unnecessary services
- "Upcoding," or using a code that provides for higher payment than what reflects the service actually provided

- Claims for outpatient services that should have been considered part of an inpatient stay
- Teaching hospitals' practices of billing for services actually performed by interns and residents (Physicians At Teaching Hospitals or [PATH] initiative)
- Duplicate billing (more than one claim for the same service or filing claims with multiple primary payers), false cost reports (particularly, home health agencies and other providers continuing to be cost reimbursed), unbundling (fragmenting what is considered a single service—for example, a lab test—to increase reimbursement), and billing for a patient discharge rather than a transfer
- Patients' freedom of choice, particularly related to discharge planning activities
- Failure to refund credit balances
- Hospital incentives that violate the antikickback statutes or other similar federal or state laws (including excessive payments to physicians for services or for their medical practices)
- Joint ventures or other financial arrangements between hospitals and hospital-based physicians
- The Limitations on Certain Physician Referrals law, also known as the Stark physician self-referral law. (See the Stark II Issues section of this Audit Risk Alert for more information).
- A knowing failure to provide covered services or necessary care to a member of a health maintenance organization (HMO)
- Patient dumping

The Balanced Budget Act of 1997 (BBA), as described in the New Issues discussion later in this section, did not make fundamental changes to the fraud and abuse laws to the same extent as the previous year's Health Insurance Portability and Accountability Act. However, the BBA provides for imposition of a civil money penalty of $50,000 and damages of up to three times the amount

of money involved against an entity that: (1) arranges or contracts with an individual or entity that it knows or should know has been excluded from a federal health care program; or (2) violates the antikickback provision of the Medicare and Medicaid statute.

This heightened enforcement activity should remind auditors of their professional responsibilities pursuant to SAS No. 54, *Illegal Acts by Clients* (AICPA, *Professional Standards*, vol. 1, AU sec. 317), in planning and performing their audits of health care organizations. The discussion titled Fraud and Abuse in the Health Care Industry in the Audit Issues and Developments section of this Audit Risk Alert has additional information.

Corporate Compliance

What are some of the adverse consequences facing health care organizations that do not have an effective compliance program?

Government enforcement activities such as those discussed in previous sections have brought corporate compliance to the planning forefront for many health care organizations. The formal adoption of a corporate compliance program can assist a health care organization in avoiding unlawful activities, detecting such activities before significant potential damages are incurred, and establishing that any unlawful activities in which it was engaged were inadvertent. A written corporate compliance program should consist of procedures and controls to prevent, detect, and correct wrongdoing within an organization based on the standards included in the Federal Sentencing Guidelines. Potential adverse consequences to health care organizations of not having an effective compliance program include the following:

- Probation and court-imposed program
- Government-designed integrity program
- Fines in amounts sufficient to divest the organization of all its net assets
- Exclusion from Medicare, Medicaid, or both
- Civil liability

In addition, it is of interest to note that a recent court ruling suggests that, in certain instances, a health care entity's board of directors may have breached its fiduciary duty by not considering the adoption of a compliance plan.

Corporate compliance programs are an integral part of an organization's internal control. SAS No. 55, *Consideration of Internal Control in a Financial Statement Audit*, explains how an independent auditor should consider internal control in planning and performing an audit. Auditors may wish to consider communicating with the client's board of directors or committee thereof about the organization's activities or plans regarding corporate compliance. If an organization does not have an effective corporate compliance program, the auditor should determine whether this represents a reportable condition to be reported to the audit committee. SAS No. 60, *Communication of Internal Control Related Matters Noted in an Audit* (AICPA, *Professional Standards*, vol. 1, AU sec. 325), provides guidance in identifying and reporting conditions related to an entity's internal control that are observed during a financial statement audit.

Guidance for Corporate Compliance

The OIG recently issued *Compliance Program Guidance for Hospitals* (Compliance Guidelines). This publication is intended to help hospitals implement effective internal control that promotes adherence to applicable federal and state laws and program requirements of federal, state, and private health plans. As explained by the OIG, a hospital's compliance plan should demonstrate its commitment to compliance, and "...should become part of the fabric of routine hospital operations."

Components of the Compliance Guidelines

Compliance Policies. Hospitals should develop and distribute written compliance policies that identify specific areas of risk to the hospital, including those specified in the Governmental Investigations Relating to Fraud and Abuse Violations section of this Alert. These policies and procedures should reflect and reinforce current legal requirements regarding submission of claims and Medicare cost reports and should—

- Create a mechanism for effective communications between billing or reimbursement staff and clinical staff.
- Provide for proper, timely, and legible documentation of all physician and other services before billing to ensure accuracy.
- Emphasize that claims should be submitted only when there is supporting documentation and require that information on claims reflect medical records and the availability of documentation necessary for accurate code assignment to coding staff.

In addition, compensation for billing department coders and billing consultants should not provide a financial incentive to improperly "upcode" claims.

Standards of Conduct. Hospitals should develop written standards of conduct (that is, employee handbooks) for all affected employees that include a clear commitment to compliance by the hospital. Hospitals should designate a compliance officer and provide the officer with authority necessary to implement the compliance program. The compliance function should not be subordinate to the hospital's general counsel or financial officer.

Education and Training. A hospital should require corporate officers, managers, employees, physicians, and other health care professionals to participate in regularly scheduled education and training activities. Training programs should address the hospital's compliance program, fraud and abuse laws, coding requirements, claims development and submission processes, and marketing practices. In addition to specifically identified risk areas, the educational programs should address—

- Government and private payer reimbursement principles.
- General prohibitions on paying or receiving remuneration for referrals.
- Proper confirmation of diagnoses.
- Claims for physician services rendered by nonphysicians (that is, the "incident to" rule and the physician physical-presence requirement).

- Prohibitions against signing a form for a physician without the physician's authorization, altering medical records, or prescribing medications and procedures without proper authorization.
- Proper documentation of services rendered.
- Duty to report misconduct.

Hospitals should maintain an open line of communication between the compliance officer and hospital personnel using a hotline (including an anonymous hotline), email, written memoranda, and newsletters. Employees should be permitted to report matters anonymously. Written confidentiality and nonretaliation policies should be developed and distributed to encourage reporting. The compliance officer should document and immediately investigate all reported matters and should maintain a log of calls. Information relating to reported incidents should be reported to the hospital's governing body, chief financial officer, and compliance committee.

An effective compliance program should include guidelines addressing disciplinary action for corporate officers, managers, employees, physicians, and other health care professionals who fail to comply with the hospital's standards of conduct, policies and procedures, or federal and state law. Intentional or reckless noncompliance should result in significant sanctions. Disciplinary actions may also be appropriate, based on an employee's failure to detect a violation resulting from his or her negligence or recklessness.

Precautions Against Employing Health Care Offenders. Hospitals should conduct a reasonable background investigation of any new employee who will have discretionary authority regarding legal compliance or compliance oversight, including a reference check. The applicant should be required to disclose any prior criminal conviction or exclusion action. Employment of individuals recently convicted of a criminal offense related to health care, or debarred, excluded, or otherwise ineligible for participation in a federal health program should be prohibited.

Auditing and Monitoring. Hospitals should continually audit and monitor their compliance programs, conducting regular compliance audits focusing on the programs, including their external relationships with third-party contractors. Regular, periodic compliance audits by internal or external auditors with expertise in federal and state regulatory requirements is an effective tool to promote and ensure compliance. These audits should address a hospital's compliance with applicable laws. Self-monitoring techniques may include sampling protocols that permit review of variations from established baselines and a review of any reserves the hospital has established for payments owed to a federal health care program to evaluate the need for repayment.

A hospital should evaluate periodically whether elements of its compliance program have been satisfied by conducting on-site visits, personnel interviews, and trend analyses to discover specific deviations. Additional auditing activities may include use of personnel questionnaires and review of records supporting claims for reimbursement and materials prepared by various hospital divisions. The hospital should document efforts to comply with various regulatory requirements.

Responding to Reported Offenses. A hospital should respond to "detected offenses" and develop corrective action initiatives. The OIG emphasizes that "detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of the hospital." Consequently, upon receipt of any report or reasonable indication of noncompliance, the hospital should determine whether a violation of the law or compliance program has occurred, and if so, resolve the problem, including, as appropriate, an immediate referral to law enforcement authorities, a corrective action plan, a report to the government, and return of overpayments. A hospital with credible evidence of misconduct in violation of applicable law should report the misconduct to the appropriate government authority within sixty days to "demonstrate the hospital's good faith and willingness to work with governmental authorities to correct and remedy the problem."

In addition to the corporate compliance guidance for hospitals, the OIG also published compliance program guidance for clinical lab-

oratories and home health agencies. The OIG is also expected to issue compliance guidance for other health care organizations, such as durable medical equipment suppliers and managed care organizations. Until such guidance is issued, these organizations should refer to the existing OIG compliance guidelines.

The OIG's Web site contains the full text of all compliance program guidance as well as its semiannual reports and work plans. The Web site can be located at http://www.dhhs.gov/progorg/oig.

Executive Summary—Corporate Compliance

- Government enforcement activities have brought corporate compliance to the planning forefront for many health care organizations. A formal corporate compliance program can assist in avoiding unlawful activities, detecting such activities before damages are incurred, and establishing that any unlawful activities were inadvertent.
- Auditors of health care organizations that do not have an effective program in place should consider whether this constitutes a reportable condition to be reported to the audit committee. SAS No. 60, *Communication of Internal Control Related Matters Noted in an Audit,* provides guidance in such circumstances.
- The OIG's *Compliance Program Guidance for Hospitals* outlines the components of compliance guidelines, which include: compliance policies, standards of conduct, education and training, precautions against employing health care offenders, auditing and monitoring, and responding to reported offenses.

Major Changes to Single Audits of Federal Awards

How do the amendments to the Single Audit Act affect audits of federal awards?

Single Audit Act Amendments of 1996

Legislation amending the Single Audit Act of 1984 (Public Law 104-156), was signed into law on July 5, 1996, as the Single Audit Act Amendments of 1996 and is effective for fiscal years beginning after June 30, 1996. A brief description of the 1996 amendments as contrasted with the Single Audit Act of 1984 is shown in the following table.

	1996 Act	*1984 Act*
Applicability	State and local governments, Indian tribal governments, and not-for-profit organizations (including hospitals)	State and local governments and Indian tribal governments
Single audit threshold	$300,000 in federal awards *expended* in year	$100,000 in federal assistance *received* in year
Major federal program	Generally determined by the auditor on a risk-based approach	Larger of $300,000 or 3% of federal financial award expenditures
Reporting deadline	Within 9 months of year end (after transition period)	Within 13 months of year end
Program-specific audits	Permitted if $300,000 or more expended is for 1 federal program	Not addressed

Copies of the 1996 amendments are available through the AICPA Fax Hotline, by dialing (201) 938-3787 from a fax machine and selecting document number 402.

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*

On April 22, 1996, the Office of Management and Budget (OMB) issued a revised Circular A-133, applicable only to not-for-profit organizations. Once the 1996 amendments were passed (see the discussion in the previous section), it became necessary for the OMB to propose another revision to OMB Circular A-133 to add state and local governments to the scope of the Circular, to comply with certain other aspects of the 1996 amendments, and to rescind Circular A-128, which is the existing regulation governing audits of federal awards for states and local governments. The revised Circular A-133 was issued on June 30, 1997, and it applies to audits of fiscal years beginning after June 30, 1996.

The major differences between the revised Circular A-133 and Circulars A-128 and A-133 are outlined in the following table.

	Revised A-133	*A-128*	*A-133*
Applicability	State and local governments, Indian tribal governments, and not-for-profit organizations (including hospitals)	State and local governments and Indian tribal governments	Not-for-profit organizations
Audit threshold	$300,000 expended, single audit if more than 1 federal program	$100,000 received, mandatory single audit	$100,000 received, either single audit or program-specific audit
	$300,000 expended, program-specific audit if only one program	$25,000–$100,000 received, option for single audit or program-specific audit	$25,000–$100,000 received, option for single audit or program-specific audit
	Below $300,000 expended, no single audit requirements	Below $25,000 received, no audit required	Below $25,000 received, no audit required
Major federal program	Generally determined by the auditor on a risk-based approach	Larger of $300,000 or 3% of federal financial award expenditures	Larger of $100,000 or 3% of federal financial award expenditures
Reporting deadline	Within 9 months of year end (after transition period)	Within 13 months of year end	Within 13 months of year end

Some additional provisions of the revised Circular include the following:

- The required level of testing of internal control over major programs is clarified as being based on auditors' planning for a low assessed level of control risk.
- Guidance is included for conducting program-specific audits covering those situations in which a federal grantor agency has not issued a program-specific audit guide, as well as those situations in which a program-specific audit guide has been issued by the grantor agency.
- Minimum requirements for the schedule of expenditures of federal awards are provided.
- Guidance is included concerning the following:
  1. Reporting audit findings in a single schedule of findings and questioned costs, which includes a summary of the

auditor's results, and findings and questioned costs related to the financial statement audit as well as to federal awards

2. Thresholds for determining which audit findings should be included in the schedule of findings and questioned costs
3. Descriptions of what information auditors should include in an audit finding
4. Required follow-up on audit findings

- Auditee management is required to provide a corrective action plan for current-year audit findings and a summary schedule reporting the status of prior-year audit findings.
- Restrictions are imposed on auditor selection whereby auditors who prepare the indirect cost proposal or cost allocation plan are prohibited from being selected as the auditor if the indirect costs recovered in the prior year are greater than $1 million in total. This provision is effective for audits of fiscal years beginning after June 30, 1998.

As a result of the issuance of the 1996 amendments and revisions to OMB Circular A-133, questions have arisen about the status of position statements issued by the President's Council on Integrity and Efficiency (PCIE). These position statements were originally developed to address issues related to audits conducted under the Single Audit Act of 1984, OMB Circular A-128, and the March 1990 version of OMB Circular A-133. Therefore, with the exception of PCIE Statement No. 4, none of the remaining position statements is applicable to audits conducted under the 1996 amendments or the new OMB Circular A-133 requirements.

For a copy of the revised Circular A-133, refer to the June 30, 1997, *Federal Register* or call the OMB Fax Information Line at (202) 395-9068, document number 1133.

Compliance Supplement

In the June 10, 1998, *Federal Register*, OMB published notice of the availability of the 1998 Circular A-133 *Compliance Supple-*

ment (1998 Supplement). The revised OMB 1998 *Compliance Supplement* supersedes all previously issued Supplements and sets forth the material compliance requirements that are to be included in an audit in accordance with OMB Circular A-133. It covers states, local governments, and not-for-profit organizations and applies to audits of fiscal years beginning after June 30, 1997. The significance of this document is stated in Part I of the *Compliance Supplement*:

> This document serves to identify existing important compliance requirements which the Federal Government expects to be considered as part of an audit required by the 1996 amendments. Without this Supplement, auditors would need to research many laws and regulations for each program under audit to determine which compliance requirements are important to the Federal Government and could have a direct and material effect on a program. Providing this Supplement is a more efficient and cost effective approach to performing this research. For the programs contained herein, this Supplement provides a source of information for auditors to understand the Federal program's objectives, procedures, and compliance requirements relevant to the audit as well as audit objectives and suggested audit procedures for determining compliance with these requirements.
>
> This Supplement also provides guidance to assist auditors in determining compliance requirements relevant to the audit, audit objectives, and suggested audit procedures for programs not included herein. For single audits, this Supplement replaces agency audit guides and other audit requirement documents for individual Federal programs.
>
> OMB Circular A-133 provides that Federal agencies are responsible to annually inform OMB of any updates needed to this Supplement. This responsibility includes ensuring that program objectives, procedures, and compliance requirements, noncompliance with which could have a direct and material effect on these individual Federal programs, are provided to OMB for inclusion in this Supplement, and that agencies keep current these program objectives, procedures, and compliance requirements (including statutory and regulatory citations).

A copy of the *Compliance Supplement* may be ordered from the Government Printing Office (Document 041-001-00507-2). See the Information Sources table at the end of this Audit Risk Alert (under U.S. General Accounting Office).

AICPA Statement of Position

Given the changes described in the preceding sections, Statement of Position (SOP) 92-9, *Audits of Not-for-Profit Organizations Receiving Federal Awards*, and certain sections of the Audit and Accounting Guide *Audits of State and Local Governmental Units* (the Guide) have become outdated. In response, the AICPA has issued a new SOP that supersedes them. SOP 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards,* was issued on March 17, 1998, and provides guidance on the auditor's responsibilities and reporting requirements for audits performed and corresponding reports issued under the 1996 amendments and OMB Circular A-133. It also includes revised simplified single audit illustrative audit reports that include one report on the financial statements, one report that meets the requirements for reporting on compliance and internal control under Government Auditing Standards (GAS, also known as the Yellow Book), and one report that meets the requirements of the 1996 amendments and OMB Circular A-133 for reporting on single audits of federal awards. See the Auditing Issues and Developments section of this Alert for a more detailed discussion of the provisions of SOP 98-3.

In addition, the AICPA Practice Aid *Auditing Recipients of Federal Awards: Practical Guidance for Applying OMB A-133,* Audits of States, Local Governments, and Non-Profit Organizations, contains comprehensive analyses and guidance on implementing the provisions of the revised OMB Circular.

The illustrative reports can be obtained through the AICPA Fax Hotline—by dialing (201) 938-3787 from a fax machine and selecting document number 311—or at the AICPA Web site, www.aicpa.org/belt/a133.htm.

Executive Summary—Major Changes to Single Audits of Federal Awards

- The Single Audit Act Amendments of 1996 made changes to the Single Audit Act of 1984 with regard to applicability, audit threshold, major federal program, reporting deadline, and program-specific audits. In response to these changes, OMB Circular A-133 was revised to conform to the 1996 act and OMB Circular A-128 was rescinded.
- A revised OMB 1998 *Compliance Supplement*, which became available in June 1998, sets forth material compliance requirements that are to be included in an audit in accordance with OMB Circular A-133. The Supplement is an efficient and cost-effective approach to researching the laws and regulations for each program under audit to determine which compliance requirements are important to the federal government and that could have a direct and material effect on the program.
- The AICPA SOP 98-3 provides guidance on the work performed and the reports issued for audits under the 1996 amendments and OMB Circular A-133.

Internal Revenue Service Developments

What are the current tax issues that may affect audits of health care organizations?

Auditors should be aware of relevant tax laws and regulations and their potential effect on health care organizations and their financial statements. A not-for-profit health care organization's failure to maintain its tax-exempt status could have serious tax consequences and affect both its financial statements and related disclosures, and such failure could possibly require modification of the auditor's report. Failure by both for-profit and not-for-profit health care organizations to comply with tax laws and regulations could have either a direct effect on the determination of financial statement amounts or an indirect effect on the financial statements that would require appropriate disclosures. In addition, intermediate sanctions allow the Internal Revenue Service (IRS) to monetarily penalize officers, directors, and other disqualified persons directly for their participation in excess benefit transactions. Although such a penalty would

likely not materially affect financial statements, the excess-benefit transaction that triggers the penalty may require disclosure.

IRS Focus on Joint Ventures

Increasingly, tax-exempt hospitals have joined forces with for-profit entities to enlarge the resource base available with which to provide quality, low-cost health care to the public. In connection with joint ventures of this type, concerns arise about whether a hospital could jeopardize its tax-exempt status or be subjected to the unrelated business income tax.

The IRS has indicated that its Coordinated Examination Program (CEP), which involves audits of large, complex exempt organizations such as nonprofit hospitals, will focus more on such joint ventures between tax-exempt organizations and taxable entities. CEP audits will be a major component of the IRS Exempt Organizations Division's work plan for this fiscal year and likely for the next fiscal year as well.

This is a follow-up to the IRS's release of Revenue Ruling 98-15, in which two situations involving whole hospital joint ventures between tax-exempt hospitals and taxable entities are discussed. According to the ruling, an Internal Revenue Code Section 501(c)(3) organization may form and participate in a partnership arrangement if—

1. Such participation furthers a charitable purpose.
2. The partnership arrangement permits the exempt organization to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit partners.

The central message of the ruling appears to be that the analysis is one of facts and circumstances; the fundamental issue is whether the exempt participant has sufficient control to ensure that the venture will be operated in an exempt manner and to prevent private inurement or impermissible private benefit.

Proposed Regulation on Disclosure

Final regulations are being developed relating to tax-exempt organization disclosure requirements under Internal Revenue Code

Section 6104(e), which requires exempt organizations to provide copies of their exemption applications and three most recent information returns on request. The new public inspection rules provide that—

1. Requests made in person must be responded to immediately.
2. Written requests must be responded to within thirty days.

Reasonable fees to cover administrative costs for postage and reproduction are permissible. Exceptions to this rule are provided if—

1. The documents are requested to harass an organization; however, the IRS has indicated that harassment campaigns probably will be "narrowly construed."
2. The documents are made "widely available" (that is, making materials available via electronic means, such as the Internet).

Failure to comply with the public inspection rules could result in a $20-per-day penalty with a $10,000 maximum, with a $5,000 penalty for willful failure.

Executive Summary—Internal Revenue Service Developments

- Auditors should be aware of relevant tax laws and regulations to assess their potential effect on health care organizations and their financial statements. For example, a not-for-profit health care organization's failure to maintain its tax-exempt status could have serious tax consequences and affect both its financial statements and related disclosures, and such failure could possibly require modification of the auditor's report.
- The IRS has indicated that its Coordinated Examination Program will focus more on joint ventures between tax-exempt organizations and taxable entities. Concerns arise in such arrangements about whether a hospital could jeopardize its tax-exempt status or be subjected to the unrelated business income tax.
- Final regulations are being developed relating to tax exempt organization disclosure requirements—they must provide copies of exemption applications and the three most recent information returns on request.

Stark II Issues

Effective January 1, 1995, the Limitations on Certain Physician Referrals law (the Stark Law) prohibits physicians from referring patients to health care organizations with which the physicians have a financial relationship for the furnishing of "designated health services" covered under Medicare or Medicaid. Although this legislation has been in effect for more than three years, little guidance has been available to the health care industry, particularly on the types of financial arrangements prohibited, the health care services covered under the statute, and how various statutory exceptions should be interpreted. On January 9, 1998, the Health Care Financing Administration (HCFA) issued proposed regulations likely to be of special interest to health care organizations, including the following:

- A physician furnishing services to a hospital as an employee or as an independent contractor cannot be required to refer patients to the hospital; otherwise, his or her compensation will impermissibly reflect the volume or value of referrals, even though payments from the hospital do not fluctuate in amount.

- A statutory requirement that leases and contracts for personal services have a contract term of at least one year does not preclude contract provisions permitting earlier contract termination for "good cause," so long as the parties do not enter into another contract arrangement within the initial one-year period.

- There is an exception for hospitals' payment of physician recruitment incentives; however, according to the proposed regulations, it protects only arrangements in which a physician residing outside a hospitals' geographic area relocates to join the hospital's medical staff. Payments to a hospital resident or other physician living within the hospital's geographic area are not protected under this exception.

- There is an exception for "in-office ancillary services," such as physician office labs operated by physicians or "group practices"; however, according to the proposed regulations,

a group practice member cannot be credited directly with revenues from designated health services he or she orders for a Medicare or Medicaid patient, even if the physician actually performs the service.

Balanced Budget Act

What are the significant provisions of the Balanced Budget Act of 1997 that will affect health care organizations in the current year?

The Balanced Budget Act of 1997 (BBA) has been characterized as having the greatest impact on the Medicare program since the inpatient prospective payment system was implemented in 1983. Overall, the federal government expects to reduce expenditures by $116 billion over five years. The BBA has such a far-reaching impact that no providers are untouched. Although certain provisions do not take effect until 1999, several were implemented in 1998, and providers will soon be subject to the remaining provisions. The home health changes, for example, are so significant that certain providers may not continue to offer this service. Other provisions not only reduce reimbursement, but also may affect the way care is delivered. The following is a brief summary of certain of the more significant provisions whose impact will be felt during 1998.

Hospital Inpatients

For federal fiscal year 1998 (through September 30, 1998) payment rates for inpatient services were generally frozen at prior-year levels. Future annual updates are tied to health care inflation less 1 percent to 2 percent. The federal fiscal year 1999 (effective October 1, 1998) is estimated at 0.5 percent for most providers. Additionally, for ten Diagnosis-Related Groupings (DRGs), certain discharges from the inpatient setting to post-acute-care settings, such as home health or skilled nursing, are to be considered transfers rather than discharges. This provision, which is effective October 1, 1998, will affect reimbursement by reducing DRG payments to offset reimbursement to other providers, such as home health care or skilled nursing facilities. In addition, academic medical centers and teaching hospitals will see significant

cuts in indirect medical education funding in federal fiscal year 1999, increasing each fiscal year until 2002.

Skilled Nursing Facilities

Effective for cost-reporting periods beginning on or after July 1, 1998, a skilled nursing facility (SNF) prospective payment system (PPS) is to be implemented. SNF PPS rates, which will be phased in over three years, are to include all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs). SNFs are also required to provide Medicare with consolidated billing, a comprehensive billing requirement (similar to the one in effect for inpatient hospital services for more than a decade) under which the SNF itself is responsible for billing Medicare for virtually all the services to its residents.

Home Health

Home health services are to be covered by a PPS for years beginning on or after October 1, 1999. Payments under the PPS are the lesser of allowable costs, per-visit limits or per-beneficiary limits. The per-beneficiary limits in particular will have a very negative impact on reimbursement for agencies that treat complex patients requiring high levels of service.

Hospital Outpatients

BBA introduced a PPS methodology for hospital outpatients. Beginning January 1, 1999, Medicare payments for outpatient services will be housed in this PPS, much like inpatient care is paid for today. All hospital departments will be covered except those already covered by another fee schedule (for example, ambulance, dialysis, and laboratory). Payments for services will include drugs, supplies, and operating room observation. The ambulatory payment classification (APC) system will be used to establish a distinct payment for each group of diagnosis or procedure circles. Because of year 2000 information system issues, the HCFA has announced it is delaying the implementation of an outpatient PPS methodology until after January 1, 2000.

Other Hospital Provisions

The BBA also reduced Medicare reimbursement by eliminating the formula-driven overpayment for outpatient services.

Capital Risk Requirements for Managed Care Organizations

Risk-Based Capital Requirements

The risk-based capital (RBC) formula is one of the tools used by regulators to evaluate the financial health of regulated entities. It is a method of measuring the minimum amount of capital appropriate for a health care organization to support its overall business operations in consideration of its size, structure, and risk profile.

The final National Association of Insurance Commissioners (NAIC) formula for managed care organizations (MCO), RBC was approved at the December 1997 NAIC meeting. Health care organizations will be required to report RBC results for the first time in their 1998 annual statements. Five principal risk elements to the MCO RBC formula are: affiliated investment risk, asset risk, underwriting risk, credit risk, and general business risk. Four action levels (in order of increasingly stringent level of regulatory response) are: company action level, regulatory action level, authorized control level, and mandatory control level. At a minimum, the company action-level event requires the filing with the respective state insurance commissioner an RBC plan detailing conditions leading to the event and proposals of corrective action.

Codification of Statutory Accounting Principles for Managed Care Entities

In March 1998, the NAIC finalized the Codification of Statutory Accounting Principles (SAP) guidance, which will replace the current *Accounting Practices and Procedures* manual as the NAIC's primary guidance on statutory accounting. The Codification provides guidance for areas in which statutory accounting has been silent and changes current statutory accounting in some areas; for example, deferred income taxes are recorded.

The NAIC adopted a recommendation to state insurance departments that they adopt the Codification guidance as soon as possible,

with an effective date of January 1, 2001. States may, however, elect effective dates before or after that date.

Companies will not be required to follow the Codification guidance until it is adopted by the state of domicile. Until the state of domicile adopts the Codification, consideration should be given to disclosure in the financial statements prepared in conformity with generally accepted accounting principles (GAAP), if the effect of the adoption is expected to be material or in situations in which the client has not determined the effect of the Codification. In addition, practitioners should consider whether going-concern issues exist as a result of the financial statement effect of the adoption of Codification. This includes consideration of the effect on RBC.

There are eight proposed Statements of Statutory Accounting Principles (SSAPs) for managed health care entities that have been specifically modified to address issues related to managed care. It is anticipated that all other SSAPs will apply if applicable to the entity. This could lead to significant changes in accounting for some companies, because statutory accounting guidance for health care organizations was silent in many areas.

Audit Issues and Developments

New SOP on Auditing Federal Awards Issued

How will the new SOP 98-3 assist auditors in performing audits of federal awards?

As a result of the numerous changes in the single audit arena (described in the Regulatory, Legislative, and Other Developments section of this Alert), the AICPA has issued SOP 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards.* The SOP provides auditors of states, local governments, and not-for-profit organizations with guidance relating to their responsibilities and reporting requirements in audits performed and corresponding reports issued under the Single Audit Act Amendments of 1996 and Circular A-133. In addition

to providing an overview of the auditor's responsibilities in an audit of federal awards, SOP 98-3—

- Describes the auditor's responsibility for testing and reporting on the financial statements and the schedule of expenditures of federal awards.
- Discusses various planning and other special audit considerations of Circular A-133, including establishing an understanding with the auditee, initial-year audit considerations, the additional requirements of *Government Auditing Standards,* and audit materiality considerations.
- Describes the auditor's responsibility for considering internal control and for performing tests of compliance with applicable laws, regulations, and program compliance requirements under GAAS, *Government Auditing Standards*, and Circular A-133.
- Includes an entire chapter devoted to the determination of major programs and the risk-based approach.
- Describes the auditor's responsibility for reporting and provides illustrations of the reports required by *Government Auditing Standards* and Circular A-133.
- Describes the auditor's responsibility for testing and reporting in a program-specific audit and provides illustrations of the related reports.
- Includes an illustrative schedule of findings and questioned costs and illustrative schedules of expenditures of federal awards.

Further, the SOP incorporates guidance from the following documents:

- The Single Audit Act Amendments of 1996 and Circular A-133 (Both of these documents are included as appendixes to the SOP.)
- Various AICPA SASs, including SAS No. 74, *Compliance Auditing Considerations in Audits of Governmental Entities*

and Recipients of Governmental Financial Assistance (AICPA, *Professional Standards,* vol. 1, AU sec. 801)

- *Government Auditing Standards* (1994 revision)
- The OMB Circular A-133, *Compliance Supplement* (June 1997 revision)

Compliance With Medicare and Medicaid Laws and Regulations

The government's recent focus on health care fraud and abuse, as previously discussed, has resulted in instances of fines and penalties that were material to the provider's financial statements, for violations of billing laws and regulations and violations of cost report reimbursement regulations. Many providers of service to Medicare have potential exposure to fines and penalties as a result of billing or cost reporting issues.

A corporate compliance program (see the Regulatory, Legislative, and Other Developments section of this Alert) or similar controls are a component of a health care organization's internal control.

Fraud and Abuse in the Health Care Industry

What effect do the allegations of violations of laws and regulations in the health care industry have on this year's audits?

Allegations of violations of laws and government regulations continue to increase in virtually all sectors of the health care industry. The allegations concern violations of a wide variety of laws and regulations, such as the Medicare and Medicaid Anti-Kickback Statute, Limitations on Certain Physician Referrals (the Stark law), and the False Claims Act, among others. Penalties for violating the laws may include denial of otherwise valid Medicare and Medicaid claims, fines, and civil money penalties (for example, treble damages, plus $5,000 to $10,000 per claim) and exclusion from the Medicare and Medicaid programs.

When auditing health care organizations, auditors should be alert to the possibility of illegal acts. SAS No. 54, *Illegal Acts by Clients*, prescribes the nature and extent of the consideration that auditors

should give to the possibility of illegal acts by a client in audits of financial statements in accordance with GAAS and provides guidance on the auditor's responsibilities when a possible illegal act is detected. The AICPA Audit and Accounting Guide *Health Care Organizations* further describes the application of SAS No. 54 in audits of financial statements of health care organizations.

Audit Procedures

SAS No. 54 notes that even in the absence of evidence concerning illegal acts, auditors should make certain inquiries of management about such matters as the client's policies relative to the prevention of illegal acts, the use of directives issued by the client, and periodic representations obtained by the client from management at appropriate levels of authority concerning compliance with laws and regulations. (Refer to the discussion titled Corporate Compliance, in the Regulatory, Legislative, and Other Developments section of this Audit Risk Alert for additional information.) Certain procedures, although not specifically designed to detect illegal acts, may bring possible illegal acts to an auditor's attention. Such procedures include reading minutes of board of directors meetings; inquiring of the client's management and legal counsel concerning litigation, claims, and assessments; or performing substantive tests of details of transactions or balances. These considerations take on increasing importance when conditions such as those currently encountered in the health care industry exist.

Pursuant to SAS No. 85, *Management Representations* (AICPA, *Professional Standards*, vol. 1, AU sec. 333), auditors ordinarily obtain written representations from management concerning the absence of violations or possible violations of laws or regulations whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency. Given the increase in allegations of violations of laws and government regulations in the health care industry, the auditor may consider obtaining additional representations relating to, for example, management's knowledge of potential fraud and abuse violations. Some of the representations that the auditor might consider obtaining include the following:

- Receivables
  - Adequate provision has been made for estimated adjustments to revenue, such as for denied claims, changes to (DRG) assignments, and cost-report audits.
  - Recorded reserves are necessary, appropriate, and properly supported.
  - All peer review organizations, fiscal intermediary, and third-party payer reports and information have been made available.
  - All required Medicare, Medicaid, and similar reports have been properly filed.
  - Appropriate provision has been made for audit adjustments by intermediaries, third-party payers, or other regulatory agencies.
- Contingencies
  - There are no violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statute, Limitations on Certain Physician Referrals (the Stark law), and the False Claims Act, in any jurisdiction whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements.
  - Billings to third-party payers comply in all respects with applicable coding principles and laws and regulations (including those dealing with Medicare and Medicaid antifraud and abuse), and reflect charges only for goods and services that were medically necessary; properly approved by regulatory bodies (for example, the Food and Drug Administration), if required; and properly rendered.
  - There have been no communications (oral or written) from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in

any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

In addition, auditors should refer to the guidance in SAS No. 85, *Management Representations* (AICPA, *Professional Standards,* vol. 1, AU sec. 333).

SAS No. 54 also provides guidance on auditors' responsibilities if specific information concerning a possible illegal act comes to their attention. The SAS states that when the auditor concludes, based on information obtained and, if necessary, consultation with legal counsel, that an illegal act has or is likely to have occurred, the auditor should consider the effect on the financial statements as well as the implication for other aspects of the audit.

When such circumstances occur, evaluating the adequacy of accrual for or disclosure of the potential effects of illegal acts in the financial statements of health care organizations is a matter that is likely to require a high level of professional judgment.

Because of the complex nature of Medicare and Medicaid laws and because such laws are subject to interpretation, auditors should suggest that health care organizations with material amounts of Medicare or Medicaid revenues disclose the significance of such revenues (in dollars or percentages) and describe the complex nature of applicable laws and regulations. They might also consider suggesting that the financial statements state management's belief that they are in compliance with the applicable laws and regulations, but indicate that the possibility of future government review and interpretation exists.

If investigations of alleged illegal acts are currently in process, or if claims have been threatened or asserted, additional disclosures may be required by FASB Statement No. 5, *Accounting for Contingencies* (FASB, *Current Text,* vol. 1, sec.C59). Auditors also may want to consider whether, in view of the far-reaching nature of alleged violations of laws and regulations in the health care in-

dustry, the disclosure requirements of SOP 94-6, *Disclosures of Certain Risks and Uncertainties*, have been met.

Representations from legal counsel are often key audit evidence. The inability of an attorney to form an opinion on matters about which he or she has been consulted may be indicative of an uncertainty that should be disclosed in the financial statements in accordance with FASB Statement No. 5 or SOP 94-6. SAS No. 58, *Reports on Audited Financial Statements* (AICPA, *Professional Standards*, vol. 1, AU sec. 508), states that if the auditor concludes that a matter involving a risk or an uncertainty is not adequately disclosed in the financial statements in conformity with GAAP, the auditor should express a qualified or an adverse opinion. Such judgments should be made in the context of the financial statements taken as a whole and in light of the surrounding circumstances. When considering procedures for identifying litigation, claims, and assessments and for the financial accounting and reporting for such matters when performing an audit in accordance with GAAS, auditors should refer to the guidance set forth in SAS No. 12, *Inquiry of a Client's Lawyer Concerning Litigation, Claims, and Assessments* (AICPA, *Professional Standards*, vol. 1, AU sec. 337).

Reporting to the Government

Instances have been noted in practice in which officials of various federal regulatory agencies (such as assistant inspectors general) have indicated that auditors have an obligation to report any identified illegal acts directly to the inspectors general or other regulatory officials. In evaluating their responsibilities in response to such requests, auditors should consider the guidance in paragraph 23 of SAS No. 54, which provides guidance on disclosure of an illegal act to parties other than the client's senior management and its audit committee, and consult with their legal counsel.

Executive Summary—Fraud and Abuse in the Health Care Industry

- Allegations of violation of laws and governmental regulations continue throughout the health care industry concerning the Medicare and Medicaid Anti-Kickback Statute, Limitations on Certain Physi-

cian Referrals, and the False Claims Act, among others. Thus, auditors should be aware of their responsibilities pursuant to SAS No. 54, *Illegal Acts by Clients.*

- Obtaining representations from the client's management and from legal counsel may be especially important in the current environment. Auditors should consider the guidance set forth in SAS No. 85, *Management Representations*, and SAS No. 12, *Inquiry of a Client's Lawyer Concerning Litigation, Claims, and Assessments.*

Obligated Group Financial Statements

Can obligated group financial statements be included in a public offering?

Obligated group is a term used to denote a group of entities, sometimes a parent corporation and several of its subsidiaries, that is liable for the repayment of an obligation, such as a tax-exempt bond. Financial information related to the obligated group is useful to the owner of the debt instrument. Obligated group financial statements often exclude entities that are required to be consolidated by GAAP. Such financial statements cannot be used as the reporting entity's general-purpose financial statements because they are not prepared in accordance with GAAP. They may, however, be issued as special-purpose financial statements with distribution limited to specified users (that is, the company and other parties to the debt agreement). It would not be appropriate to include such special-purpose financial statements in a public offering (see Interpretation No. 13, "Reporting on a Special-Purpose Financial Statement That Results in an Incomplete Presentation But Is Otherwise in Conformity With Generally Accepted Accounting Principles," of SAS No. 62, *Special Reports* [AICPA, *Professional Standards*, vol. 1, AU sec. 9623.80.-81]).

With respect to public offerings, two alternatives are available to auditors:

1. The auditor may opine on consolidated financial statements and include supplementary consolidating financial information that displays totals for the obligated group. Because the consolidated financial statements include all

entities required to be consolidated under GAAP, the auditor's report on the consolidated statements need not be limited in its distribution.

2. The auditor may opine on the consolidated financial statements that are included as an appendix in the public offering, with management providing an unaudited reconciliation of the amounts in the obligated group financial statements to the audited consolidated financial statements.

New Auditing Pronouncements

SAS No. 86

In March 1998, the Auditing Standards Board (ASB) issued SAS No. 86, *Amendment to Statement on Auditing Standards No. 72,* Letters for Underwriters and Certain Other Requesting Parties (AICPA, *Professional Standards,* vol. 1, AU sec. 634), to reflect the March issuance of Statement on Standards for Attestation Engagements (SSAE) No. 8, *Management's Discussion and Analysis* (AICPA, *Professional Standards,* vol. 1, AT sec. 700). SSAE No. 8 provides guidance on the performance of examinations and reviews of management's discussion and analysis (MD&A) prepared pursuant to the SEC's rules and regulations. SAS No. 86 allows practitioners that have examined or reviewed MD&A in accordance with SSAE No. 8 to state that fact in the introductory section of the comfort letter and attach a copy of the SSAE No. 8 report to the comfort letter. SAS No. 86 presents examples of comfort letters that contain references to either an examination of annual MD&A or a review of interim MD&A. SAS No. 86 is effective for comfort letters issued on or after June 30, 1998.

SAS No. 87

In September 1998, the ASB issued SAS No. 87, *Restricting the Use of an Auditor's Report* (AICPA, *Professional Standards,* vol. 1, AU sec. 532), which is effective for reports issued after December 31, 1998. SAS No. 87 provides guidance to auditors in determining whether an engagement requires a restricted-use report and, if so, what ele-

ments to include in that report. The SAS states that an auditor should restrict the use of a report in the following circumstances:

1. The subject matter of the auditor's report, or the presentation being reported on, is based on measurement or disclosure criteria contained in contractual agreements or regulatory provisions that are not in conformity with GAAP or other comprehensive basis of accounting (OCBOA).
2. The accountant's report is based on procedures that are specifically designed and performed to satisfy the needs of specified parties who accept responsibility for the sufficiency of the procedures.
3. The auditor's report is issued as a by-product of a financial statement audit and is based on the results of procedures designed to enable the auditor to express an opinion on the financial statements taken as a whole, not to provide assurance on the specific subject matter of the report.

In addition to describing the circumstances in which the use of an auditor's report should be restricted, the proposed Statement, among other things, defines the terms *general use* and *restricted use*, specifies the language to be used in restricted-use reports, and requires an auditor to restrict a "combined" report if it covers subject matter or presentations that ordinarily do not require a restriction on use and subject matter or presentations that require such a restriction. It permits auditors to include a separate general-use report in a document that also contains a restricted-use report.

Both the report on compliance and internal control over financial reporting issued by the auditor in an audit of financial statements performed in accordance with *Government Auditing Standards* and the report issued on compliance and internal control over compliance in a Circular A-133 audit are considered restricted-use reports. Auditors of health care organizations for whom such reports must be issued should consider the provisions of SAS No. 87.

For information on other auditing pronouncements issued this year, see the *Audit Risk Alert—1998/99.*

Year 2000 Issues

What is the Year 2000 Issue? How will it affect health care organizations?

The Year 2000 Issue relates to the inability of many electronic data processing systems to accurately process year–date data beyond the year 1999. This is because the majority of computer programs in use today have been designed to store dates in the dd/mm/yy (date/month/year) format, thus allowing only two digits for each date component. So, for example, the date December 31, 1998, is stored in most computers as "12/31/98." Inherent in programming for dates in this manner is the assumption that the designation "98" refers to the year 1998. Initially developed as a cost-saving technique, this long-standing practice of using two-digit-year input fields will cause many computers to treat the entry "00" as 1900. Therefore, such programs will recognize the date January 1, 2000 (01/01/00), as January 1, 1900, and process that data incorrectly, or perhaps not at all.

There are other possible complications as well. The year 2000 is a leap year. Systems that are not year 2000 ready may not register the additional day, thus producing incorrect results for date-related calculations. In addition, certain year 2000 problems may occur this year. For example, some software programs may have assigned special meanings to date entries coded "xx/xx/98" or "xx/xx/99" to allow for the testing of software modifications. Therefore, actual transactions using such dates may not be processed correctly or stop functioning. Failures may take place currently when systems perform calculations into or beyond the year 2000.

Health care organizations face unique year 2000 issues that may affect the entire organization, not just those departments that are affected by information technology. Although the Year 2000 Issue may seem more likely to affect areas relating to information processing, such as patient accounting—that is, invoice dates, dates of services, billing and due dates, and aging—problems could also arise that compromise patient care, disrupt business functions, and increase exposure to business and legal risks. To complicate matters, the health care industry's year 2000 readiness efforts appear to be significantly behind those of other industry groups. Re-

cent research suggests that almost two-thirds of health care organizations have not yet started to address the Year 2000 Issue, and hospitals in particular are behind. Those organizations that have started appear to be in the early stages of addressing the issue.

The Year 2000 Issue is also a concern to federal regulators. For example, the HCFA is warning Medicare contractors to become year 2000 ready by 1999 or face losing their Medicare business. The HCFA is establishing guidelines to contractors for intended year 2000 remediation plans.

Among the factors that pose significant, unique risks for health care organizations are the following:

- The Year 2000 Issue is not necessarily limited to computers but may extend to medical devices with imbedded computer chips that are date-sensitive. Such equipment could include life-saving mechanisms, such as heart defibrillators, pacemakers, and intravenous pumps.[1] Though it is estimated that less than 20 percent of such equipment may have year 2000 problems, they must nevertheless be inventoried and assessed.

- Health care organizations will have to make sure that vendor-supplied software is year 2000 ready. This problem is likely to be particularly acute, given that approximately 70 percent to 80 percent of computer software used by health care organizations is developed by third-party vendors. Remediation of such software may be beyond the control of internal information technology staff. As such, there will be heavy reliance on outside vendors to provide information technology solutions. The risk is therefore greater that health care organizations will be exposed to a vendor's failure to support installed versions of a product or applications.

1. An independent project is being conducted to develop a shared database that assesses the potential impact of the Year 2000 Issue on the proper functioning of certain medical devices. The study divides medical devices into three categories: those with no reliance on dates, those with date reliance that is not expected to affect the operation of the device, and those with date reliance that could be affected by the Year 2000 Issue. The results data have been provided by different hospitals and primary owners of such data with the intent to share this information with others in the health care field. Further information can be obtained by calling (212) 539-3072.

- Financial pressures related to consolidation and regulation in the insurance and health care industry are putting pressure on information-technology budgets, thus limiting the resources available to address the Year 2000 Issue.
- Many health care organizations make extensive use of the electronic exchange of information and payments with insurers and claims processors, physician practices, and affiliated organizations, raising the risks of external contamination as well as the effort associated with ensuring that these external interfaces are all documented and year 2000 ready.
- As hospitals move toward "just-in-time" computerized delivery systems, supply-chain year 2000 readiness must be assessed and appropriate contingency plans put in place, because vital supplies, goods, and services come from businesses outside of the health care organization. Assessments must extend beyond distributors to materials manufacturers.

Auditors should be aware of the many auditing and accounting issues that arise from the Year 2000 Issue, including audit planning, going-concern issues, establishing an understanding with the client, valuation, impairment, revenue and expense recognition, and disclosure. A more comprehensive discussion of this topic can be found in the *Audit Risk Alert—1998/99.*

In addition, Internet Web sites that might provide useful year 2000 information to auditors include the following:

- http://www.Rx2000.org—Rx2000 Solutions Institute, health care's year 2000 information clearinghouse
- http://www.hcfa.gov—the HCFA's Web site
- http://www.aicpa.org—the AICPA's Web site
- http://www.sec.gov—Statement of the Commission Regarding Disclosure of Year 2000 Issues and Consequences by Public Companies, Investment Advisers, Investment Companies, and Municipal Securities Issuers
- http://www.y2kgov.au/biomed/index.html—Biomedical Database, sponsored by the Australian government

Executive Summary—Year 2000 Issues

- Unless corrective actions are taken, the Year 2000 Issue may cause accounting and financial information systems to produce inaccurate date-related output. Certain problems could arise during 1998 and 1999.
- Year 2000 failures may affect more than just patient accounting. Health care organizations may see disruptions in patient care, as well.
- Health care organizations may be exposed to risks with medical equipment containing imbedded computer chips that are date sensitive, with vendor-supplied software for which no support is available, and with electronic information exchange that is not year 2000 ready.
- Many auditing and accounting issues arise from the Year 2000 Issue, including audit planning, going-concern issues, establishing an understanding with the client, valuation, impairment, revenue and expense recognition, and disclosure. A more comprehensive discussion of this topic can be found in the *Audit Risk Alert—1998/99.*

Accounting Issues and Developments

What are the recently issued auditing and accounting pronouncements affecting health care organizations?

Newly Issued SOPs

Joint Activities

In March 1998, the AICPA issued SOP 98-2, *Accounting for Costs of Activities of Not-for-Profit Organizations and State and Local Governmental Entities That Include Fund Raising.* The SOP applies to not-for-profit organizations and state and local governmental entities in determining fund-raising costs. It supersedes SOP 87-2, *Accounting for Joint Costs of Informational Materials and Activities of Not-for-Profit Organizations That Include a Fund-Raising Appeal,* and amends existing guidance in the Audit and Accounting Guide *Health Care Organizations* (as well as the *Not-for-Profit* and *State and Local* Guides). SOP 98-2 requires entities to report as fund-raising costs the costs of all materials and activities that include a fund-raising appeal. These costs include those that otherwise might be considered program or management and general costs if they had been incurred in a different activity, un-

less the criteria of purpose, audience, and content, as defined in the SOP, are each met, subject to the following exception. Costs of goods or services provided in exchange transactions, such as costs of direct donor benefits of a special event (for example, a meal), should not be reported as fund raising. If the criteria of purpose, audience, and content are met, the joint costs of those activities should be allocated and costs that are clearly identifiable with fund-raising, program, or management and general functions should be charged to those cost objectives.

SOP 98-2 applies to all nongovernmental not-for-profit organizations and all state and local governmental entities that solicit contributions and is effective for years beginning on or after December 15, 1998. Some entities will undoubtedly change the way they conduct their activities to meet the allocation criteria. The lead time on conducting such activities can be as long as six months. Auditors should discuss the SOP with their clients and start reviewing their activities now to plan for implementation of the SOP.

Because of pressure to portray fund-raising expenses within certain percentages of revenue and expenses, there continues to be an increased risk that the cost of mailing materials or conducting other communications with the public may not be properly allocated between program expenses and fund-raising or management and general expenses.

Some state attorneys general continue to criticize the manner in which some organizations allocate joint costs. They believe that some organizations have been too liberal in their allocation of costs to program expenses, especially those costs incurred to educate the public.

Not-for-profit health care organizations and auditors should carefully review the requirements of the applicable SOP and consider the sufficiency of evidence that exists to support any allocations of such joint costs.

Internal Use Software

In March 1998, Accounting Standards Executive Committee (AcSEC) issued SOP 98-1, *Accounting for the Costs of Computer*

Software Developed or Obtained for Internal Use. The SOP requires that entities capitalize certain internal-use software costs once certain criteria are met. The SOP identifies the characteristics of internal-use software and provides examples to assist in determining whether computer software is for internal use. The SOP applies to all nongovernmental entities and is effective for financial statements for fiscal years beginning after December 15, 1998, though earlier adoption is encouraged.

Start-Up Activities

In April 1998, AcSEC issued SOP 98-5, *Reporting on the Costs of Start-Up Activities.* The SOP requires that entities expense the costs of start-up activities and organization costs as incurred. The SOP broadly defines start-up activities and provides examples, including an example specific to not-for-profit organizations, to help entities determine what costs are and are not within the scope of the SOP. The SOP applies to all nongovenmental entities and, except for certain investment companies, is generally effective for financial statements for fiscal years beginning after December 15, 1998, though earlier adoption is encouraged.

SEC Issues and Developments

What are some issues of concern this year for health care organizations subject to SEC regulations?

Goodwill Lives

The SEC staff continues its scrutiny of goodwill lives, both for initial and existing registrants, as well as registrants with business combinations accounted for as purchases and those that have recently experienced significant events, such as a writeoff of goodwill, a major restructuring, a history of recent losses or the sale of a division at a loss. Although the SEC staff has not objected to longer-term amortization periods in certain circumstances, amortization periods of twenty-five years or less are often appropriate. Accordingly, health care organizations should be prepared specifically to support their assertion of long-term lives and should conduct a continuing assessment of initial and remaining good-

will lives. Some factors to consider when assessing initial and remaining goodwill lives include—

- Increased competition and industry consolidation.
- Changing third-party reimbursement requirements.
- Technological medical innovation.
- Employment agreements with key operating personnel or relationships with key operating personnel.
- Changing regulatory environment.

Additionally, health care organizations should be aware that the use of a "blended life" for goodwill and other intangible assets of fifteen to twenty-five years, resulting from the "blending" of goodwill with a life of forty years and other shorter-lived intangibles, is generally not supportable. APB Opinion 16, *Business Combinations*, requires that identifiable assets be separately valued and amortized.

The SEC has recently focused considerable attention on amortization periods for goodwill and management services agreement (MSA) intangibles recorded by physician practice management companies. Their most recent reviews were put forward on July 27, 1998, when a member of the SEC staff spoke at the AICPA's National HealthCare Industry Conference. In a speech on physician practice management (PPM) accounting and reporting matters, the SEC staff member noted that:

> PPMs with current amortization periods in excess of 25 years should reevaluate their amortization policy immediately and change to a shorter amortization period. While the staff believes the use of periods exceeding 25 years may have been an error in the application of GAAP, it will not object if registrants conclude that the effects should be reported as a change in estimate (as opposed to correction of an error) prospectively over the remaining revised period.

While these remarks are not binding on the SEC, PPMs should consider the necessity of conducting a thorough, continuing assessment of the lives of their recorded goodwill, MSA intangibles

and other intangible assets. Factors unique to PPMs that may be considered include—

- Ability of a management company and the medical practices to perform under the terms of a service arrangement over an extended period.
- Ability to continue revenues upon departure of key owners or physicians of the practice.
- Term(s) of employment contracts with key owners or physicians.
- Revised incentive structures.
- Ability to withstand legal challenges concerning the corporate practice of medicine.

Accounting and Disclosure by Physician Practice Management Companies

The SEC staff has issued a number of informal views on PPM accounting and reporting issues.

Financial Issues. During the consideration of the FASB Emerging Issues Task Force (EITF) Issue No. 97-2, *Accounting and Disclosure by Physician Practice Management Companies,* the SEC staff did not object to the following: The revenues and expenses of the medical practice could be displayed in the PPM's statement of operations if the management agreement terms provide the PPM with a net profits or equivalent interest in the preponderance of the medical services furnished by the medical group. A net-profits interest arises when the management fee is derived from the profit of the medical practice.

If the revenue and expenses of the medical practice are displayed in the PPM's financial statements, they must be disclosed separately on the face or in the notes. Management fee and lease income from the medical group should also be disclosed. Actual aggregate management fee income and selling general and administrative costs of the PPM must be clearly disclosed on the face of the statement of operations with note disclosure of the material contract terms bearing on their calculation. After compliance with EITF Issue No. 97-2 is required, the staff will object

to the continued display of revenues and expenses of the medical practice in this manner.

Separate Financial Statements of the Medical Practices. If the PPM is expected to have a material dependence on the medical practice, separate financial information about the practice would be material to investors. The SEC staff has accepted unaudited summary financial information for the three most recent fiscal years if audited financial statements are not readily available and its owners are not significant shareholders or promoters of the PPM. Also, if a PPM guarantees a practice's income, extends unusual credit terms, funds operating losses, or otherwise provides loans to the practice, separate financial information about that practice would be material to investors.

Disclosure Issues Include the Following.

- Business and contractual relationships should be clearly and accurately described by the offering documents and ongoing reports.
- The nature of the PPM's business and relationship to the medical practice should be included (cover topics such as contractual relationships, how PPM fees are determined, whether management fee agreements are subject to adjustment, and loan arrangements between the PPM and the medical practice).
- PPM's relationship with care providers and payors should be described (description of contracts, who bears risk, whether or not there are regulatory considerations).
- State or federal regulations applicable to the PPM should be described (including corporate practice of medicine laws, antikickback and self-referral restrictions).
- Management discussion and analysis should discuss financial terms of the management contracts and detailed disclosure of individually material agreements.
- Acquisition agreements and material management agreements should be filed.

EITF Issue No. 97-2

The EITF recently has considered matters relating to financial statement preparation as Issue No. 97-2, *Accounting and Disclosure by Physician Practice Management Companies.* On November 30, 1997, the EITF reached consensus on the various issues embodied in the Issue No. 97-2 project. Transition guidance was established in March 1998.

The Issue provides a list of criteria which, when applied to contractual arrangements between PPMs and medical practices, indicate whether the PPM should consolidate the assets and operations of the medical practice. If a contractual arrangement meets all the criteria, the PPM must consolidate the physician practice(s). Conversely, if a single area is not met, the PPM cannot consolidate the physician practice(s). The EITF concluded that when a PPM acquires the net assets and enters into long-term management service agreements with the medical entity, rather than acquiring the medical entity's stock outright, it should be considered an APB Opinion 16 business combination accounted for as a purchase if the medical entity is "a business" (this should be based on facts and circumstances), and the PPM is required to consolidate the medical entity. This acquisition cannot be accounted for as a pooling of interest. If the consolidation criteria are not met or the physician practice is not a business, the management agreement should be accounted for as a service contract.

If a PPM consolidates the physician practice, the physicians or dentists employed by the practice would be considered as employees of the PPM issuing stock options. If not, the physicians and dentists would not be considered employees. In such cases, the accounting treatment for nonemployee options under FASB Statement No. 123, *Accounting for Stock-Based Compensation* (FASB, *Current Text*, vol. 1, sec. C36) would be required.

Transition Guidance. The transition guidance provided in EITF Issue No. 97-2 is extensive and complex and therefore should be read in its entirety.

Executive Summary—Securities and Exchange Commission Issues and Developments

- The SEC staff continues its scrutiny of goodwill lives for both initial and existing registrants, and accordingly could be an area of greater audit risk this year.
- The SEC staff has issued a number of informal views on physician practice management companies relating to financial and disclosure issues.
- Accounting and disclosure by physician practice management companies have also been considered by the FASB's EITF in Issue No. 97-2.

Proposed SOP on Certain Managed Care Arrangements

AcSEC has undertaken a project on accounting for certain managed care arrangements. The proposed SOP would affect both entities following the insurance model (FASB Statement No. 60, *Accounting and Reporting by Insurance Enterprises* [FASB, *Current Text*, vol. 1, sec. In6]) and entities following the health care model (AICPA Audit and Accounting Guide *Health Care Organizations*, which incorporates SOP 89-5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services*). The SOP will likely amend *Health Care Organizations* and may amend the AICPA Audit and Accounting Guide *Audits of Stock Life Insurance Companies*. The SOP would apply to all nongovernmental entities, and potentially to certain governmental entities, undertaking managed care transactions.

The project addresses the following issues:

- *Bifurcation.* Should revenues be bifurcated between premiums and administrative fees? If so, how?
- *Reinsurance.* Should reinsurance transactions be presented gross or net in the income statement?
- *Accounting for loss contracts.* For purposes of determining whether a premium deficiency exists, should contracts be grouped? If so, how? How should costs that do not vary with a contract or group of contracts be treated? Should anticipated investment income be considered?

- *Incurred-but-not-reported (IBNR) claims.* How should IBNR claims be determined?
- *Deferred acquisition costs.* Should acquisition costs be capitalized? If so, which costs should be eligible for capitalization?

AcSEC expects to release an exposure draft of a proposed SOP for public comment in the first quarter of 1999.

Accounting for Derivatives

Issued in June 1998, FASB Statement No. 133, *Accounting for Derivative Instruments and Hedging Activities* (FASB, *Current Text*, vol. 1, sec. D50), establishes accounting and reporting standards for derivative instruments, including certain derivative instruments embedded in other contracts (collectively referred to as derivatives), and for hedging activities. It requires that an entity recognize all derivatives as either assets or liabilities in the statement of financial position and measure those instruments at fair value. If certain conditions are met, a derivative may be specifically designated as (1) a hedge of the exposure to changes in the fair value of a recognized asset or liability or an unrecognized firm commitment; (2) a hedge of the exposure to variable cash flows of a forecasted transaction; or (3) a hedge of the foreign currency exposure of a net investment in a foreign operation, an unrecognized firm commitment, an available-for-sale security, or a foreign-currency-denominated forecasted transaction.

FASB Statement No. 133 applies to all entities. A not-for-profit organization should recognize the change in fair value of all derivatives as a change in net assets in the period of the change. In a fair value hedge, the changes in the fair value of the hedged item attributable to the risk being hedged also are recognized. However, because of the format of their statement of financial performance, not-for-profit organizations are not permitted special hedge accounting for derivatives used to hedge forecasted transactions. FASB Statement No. 133 does not address how a not-for-profit organization should determine the components of an operating measure if one is presented.

FASB Statement No. 133 amends FASB Statement No. 52, *Foreign Currency Translation* (FASB, *Current Text*, vol. 1, sec. F60), to permit special accounting for a hedge of a foreign currency forecasted transaction with a derivative. It supersedes FASB Statements No. 80, *Accounting for Futures Contracts* (FASB, *Current Text*, vol. 1, sec. F80), No. 105, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk*, and No. 119, *Disclosure about Derivative Financial Instruments and Fair Value of Financial Instruments* (FASB, *Current Text*, vol. 1, sec. F25). It amends FASB Statement No. 107, *Disclosures about Fair Value of Financial Instruments* (FASB, *Current Text*, vol. 1, sec. F25), to include in FASB Statement No. 107 the disclosure provisions about concentrations of credit risk from FASB Statement No. 105. FASB Statement No. 133 also nullifies or modifies the consensuses reached in a number of issues addressed by the EITF.

FASB Statement No. 133 is effective for all fiscal quarters of fiscal years beginning after June 15, 1999. Initial application of this Statement should be as of the beginning of an entity's fiscal quarter; on that date, hedging relationships must be designated anew and documented pursuant to the provisions of this Statement. Earlier application of all of the provisions of this Statement is encouraged, but it is permitted only as of the beginning of any fiscal quarter that begins after issuance of this Statement. This Statement should not be applied retroactively to financial statements of prior periods.

For a comprehensive summary of accounting pronouncements issued this year, see the *Audit Risk Alert—1998/99.*

AICPA Audit and Accounting Literature

What other AICPA publications can be of value to auditors of health care organizations?

Audit and Accounting Guide

The AICPA Audit and Accounting Guide, *Health Care Organizations* (Product No. 012429), is available through the AICPA's

loose-leaf subscription service. In the loose-leaf service, conforming changes (those necessitated by the issuance of new authoritative pronouncements) and other minor changes that do not require due process are incorporated periodically. Paperback editions of Audit and Accounting Guides as they appear in the service are printed annually. Copies may be obtained by calling the AICPA Order Department at (888) 777-7077 or faxing a request to (800) 362-5066.

Health Care Financial Reporting Checklist

The AICPA's Accounting and Auditing Publications Division has published a revised version of the Disclosure Checklist and Illustrative Financial Statements *Health Care Organizations* (Product No. 008694), a nonauthoritative practice aid for preparers or reviewers of financial statements of health care entities. Copies may be obtained by calling the AICPA Order Department at (888) 777-7077 or faxing a request to (800) 362-5066.

Technical Practice Aids Publication

AIPCA Technical Practice Aids includes questions received by the AICPA's Technical Hotline on various subjects and the service's response to those questions. Section 6400 of *Technical Practice Aids* contains questions and answers specifically pertaining to health care entities. *Technical Practice Aids* is available both as a subscription service (Product No. G01013SM) and in paperback form (Product No. 005056). Copies may be obtained by calling the AICPA Order Department at (888) 777-7077 or faxing a request to (800) 362-5066.

National Health Care Conference

Each summer the AICPA and the Health Care Financial Management Association cosponsor a National Health Care Conference that is specifically designed to update auditors and health care financial executives on significant accounting, legal, financial, and tax developments affecting the health care industry. Information on the conference may be obtained by calling the AICPA Conferences Division at (201) 938-3556.

Continuing Professional Education

The AICPA offers the following group-study courses:

- Advising Doctors on Practice-Related Agreements in a Managed Care Environment
- Fraud in the Health Care Industry
- Health Care Industry and Medical Practice Valuation
- Managed Care Issues Into the Next Century—What the CPA Needs to Know
- Optimizing Medicare Reimbursement for Skilled Nursing Facilities
- Preparing the Medicare Cost Report for Skilled Nursing Facilities

The AICPA offers the following self-study courses:

- Doctors' Practice-Related Agreements (No. 732031JK)
- Fraud in the Health Care Industry (No. 735205JK)
- Medicare Payment Systems (No. 739010JK)

References for Additional Guidance

This Alert contains a listing of publications pertaining to health care industry trends and statistics that may be of interest to auditors of health care organizations (see the table at the end of this Alert titled Information Sources). The list is not all-inclusive and is presented for informational purposes only. It is not to be construed as an endorsement of any of the publications or organizations. Many nongovernment and some government publications and services involve a charge or membership requirement.

Fax services allow users to follow voice cues and request selected documents to be sent by fax machine. Some fax services require the user to call from the handset of the fax machine; others allow the user to call from any phone. Most fax services offer an index

document, which lists titles and other information describing available documents.

Electronic bulletin board services and Web sites allow users to read, copy, and exchange information electronically. Most are available using a modem and standard communications software. Some bulletin board services are also available using one or more Internet protocols.

Recorded announcements allow users to listen to announcements about a variety of recent or scheduled actions or meetings.

All phone numbers listed are voice lines, unless otherwise designated as fax (f) or data (d) lines.

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This Audit Risk Alert replaces *Health Care Industry Developments—1997/98.*

Auditors should also be aware of the economic, regulatory, and professional developments that may affect the audits they perform, as described in *Audit Risk Alert—1998/99.*

Copies of AICPA publications referred to in this document may be obtained by calling the AICPA Order Department at (888) 777-7077 or faxing a request to (800) 362-5066. Copies of FASB and GASB publications referred to in this document may be obtained directly from the FASB or GASB by calling the FASB/GASB Order Department at (203) 847-0700, ext. 10.

Copies of federal documents referred to in this document are available for sale from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20401; order desk telephone: (202) 783-3238; fax: (202) 512-2250.

The Health Care Industry Audit Risk Alert is published annually. As you encounter audit or industry issues that you believe warrant discussion in next year's Alert, please feel free to share them with us. Any other comments that you have about the Alert would also be greatly appreciated. You may email these comments to GDietz@aicpa.org or write to:

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APPENDIX

Applicable Authoritative Guidance for Health Care Organizations

In recent years, the AICPA, the Financial Accounting Standards Board (FASB), and the Governmental Accounting Standards Board (GASB) have issued a number of documents that clarify accounting and reporting requirements for governmental and nongovernmental entities. This section summarizes these documents and provides a roadmap to applicable guidance for various accounting and reporting issues facing investor-owned, not-for-profit, and governmental health care organizations.

In January 1992, the AICPA issued Statement on Auditing Standards (SAS) No. 69, *The Meaning of* Present Fairly in Conformity With Generally Accepted Accounting Principles *in the Independent Auditor's Report* (AICPA, *Professional Standards*, vol. 1, AU sec. 411), which redefined the generally accepted accounting principles (GAAP) hierarchy. SAS No. 69 describes the sources of established accounting principles for governmental entities and nongovernmental entities and how these sources relate to the new GAAP heirarchy.

In September 1993, the GASB issued Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and other Governmental Entities That Use Proprietary Fund Accounting,* which clarifies how FASB statements affect governmental entities that use business-type accounting and financial reporting. In all cases, governmental health care organizations are required to follow GASB pronouncements unless excluded from the scope of a particular pronouncement. GASB Statement No. 20 provides two alternatives for FASB pronouncements. Under the first, governmental health care organizations should apply FASB pronouncements (and those of its predecessors, such as the Accounting Principles Board [APB]) issued through November 30, 1989, unless those pronouncements conflict with or contradict GASB pronouncements. Under the second alternative, orga-

nizations may also elect to apply FASB pronouncements issued after that date, again, provided that they do not conflict with or contradict GASB pronouncements. Either alternative must be used consistently and disclosed in the summary of significant accounting policies note to the financial statements.

An entity meeting the definition of a governmental organization as defined in paragraph 1.02 of the AICPA Audit and Accounting Guide *Health Care Organizations* is subject to the rules promulgated by the GASB. The following matrix illustrates how an organization's classification as investor-owned, not-for-profit, or governmental determines the appropriate authoritative guidance to be applied to various accounting and reporting issues.

Area	*Investor-Owned*	*Not-for-Profit*	*Government*
Reporting Entity	Accounting Principles Board (APB) Opinion 18, *The Equity Method of Accounting for Investments in Common Stock* (FASB, *Current Text*, vol. 1, sec. I82), and FASB Statement No. 94, *Consolidation of All Majority-Owned Subsidiaries* (FASB, *Current Text*, vol. 1, sec. C51)	AICPA Statement of Position (SOP) 94-3, *Reporting of Related Entities by Not-for-Profit Organizations*	GASB Statement No. 14
Contributions and Financial Statement Display	FASB Statement No. 116, *Accounting for Contributions Received and Contributions Made* (FASB, *Current Text*, vol. 1, sec. C67)	FASB Statement No. 116 and FASB Statement No. 117, *Financial Statement of Not-for-profit Organizations*	GASB Statement No. 29, Prohibits following FASB Statement Nos. 116 and 117; NCGAS 2, *Grant, Entitlement and Shared Revenue Accounting by State and Local Governments*
Cash Flows	FASB Statement No. 95, *Statement of Cash Flows* (FASB, *Current Text*, vol. 1, sec. C25)	FASB Statement No. 95	GASB Statement No. 9
Deposits with Financial Institutions	FASB Statement No. 105, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk* (FASB, *Current Text*, vol. 1, sec. F25)	FASB Statement No. 105	GASB Statement No. 3

Area	*Investor-Owned*	*Not-for-Profit*	*Government*
Investments	FASB Statement No. 115, *Accounting for Certain Investments in Debt and Equity Securities* (FASB, *Current Text*, vol. 1, sec. I80), and Audit and Accounting Guide *Health Care Organizations* (the Guide), chapter 4	FASB Statement No. 124, *Accounting for Certain Investments Held by Not-for-Profit Organizations* (FASB, *Current Text*, vol. 2, sec. No5), and the Guide, chapter 4	GASB Statement No. 31; GASB Statement No. 3; GASB Statement No. 28 TB 94-1.
Operating Leases	FASB Statement No. 13, *Accounting for Leases* (FASB, *Current Text*, vol. 1, sec. L10)	FASB Statement No. 13	GASB Statement No. 13
Prepaid Healthcare Arrangements and Self-Insurance Programs	The Guide, chapters 8 and 14	The Guide, chapters 8 and 14	GASB Statement No. 10 as amended by GASB Statement No. 30; the Guide, chapter 14, if following the "FASB Option" provided in paragraph 7 of GASB Statement No. 20
Compensated Absences	FASB Statement No. 43, *Accounting for Compensated Absences* (FASB, *Current Text*, vol. 1, sec. C44), and FASB Statement No. 112, *Employers' Accounting for Postemployment Benefits* (FASB, *Current Text*, vol. 1, various sections)	FASB Statement Nos. 43 and 112	GASB Statement No. 16
Debt Refundings	APB Opinion 26, *Early Extinguishment of Debt* (FASB, *Current Text*, vol. 1, sec. L35), FASB Statement No. 4, *Reporting Gains and Losses from Extinguishment of Debt* (FASB, *Current Text*, vol. 1, sec. I17), and FASB Statement No. 125, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* (FASB, *Current Text*, vol. 1, secs. F35 and F38),	APB Opinion 26 and FASB Statement No. 87	GASB Statement No. 27
Pensions	FASB Statement No. 87, *Employers' Accounting for Pensions* (FASB, *Current Text*, vol. 1, sec. P16), and FASB Statement No. 132, *Employers' Disclosures about Pensions and*	FASB Statement No. 87	GASB Statement No. 27

(*continued*)

Area	*Investor-Owned*	*Not-for-Profit*	*Government*
	Other Postretirement Benefits (FASB, *Current Text*, vol. 1, secs. P16, P40)		
Risks and Uncertainties	AICPA SOP 94-6, *Disclosure of Certain Significant Risks and Uncertainties*	AICPA SOP 94-6	GASB Statements Nos. 10 and 30
Post Retirement Benefits	FASB Statement No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions* (FASB, *Current Text*, vol. 1, sec. P40)	FASB Statement No. 106	GASB Statement No. 12 supplemented by GASB Statement No. 27

The Audit Risk Alert *State and Local Governmental Developments—1998* includes a discussion of recently released GASB accounting pronouncements and projects. That Audit Risk Alert also contains valuable information on current issues and audit risks facing governmental organizations.

INFORMATION SOURCES

Organization	*General Information*	*Fax Services*	*Available Publications*
Health Care Investment Analysts, Inc. (HCIA)	*Order Department* 300 East Lombard Street Baltimore, MD 21200 Attn: Customer Service (800) 568-3282		*Comparative Performance of U.S. Hospitals: The Sourcebook* *Profile of U.S. Hospitals Guide to the Managed Care Industry* *Guide to the Nursing Home Industry*
American Association of Homes and Services for the Aging (AAHSA)	*Order Department* AAHSA Publications Dept. 5119 Washington, DC 20061-5119 (301) 490-0677		*Continuing Care Retirement Communities: An Industry in Action*
Center for Health Care Industry Performance Studies (CHIPS)	*Order Department* 1550 Old Henderson Road Suite S277 Columbus, OH 43220-3626 (800) 859-2447		*Almanac of Hospital Financial & Operating Indicators*
American Hospital Association (AHA)	*Order Department* P.O. Box 92683 Chicago, IL 90673-2683 (800) AHA-2626	Fax-on-Demand (312) 422-2020	*Hospital Statistics* *National Hospital Panel Survey Report*

(*continued*)

INFORMATION SOURCES (*continued*)

Organization	*General Information*	*Fax Services*	*Available Publications*
Group Health Association of America, Inc. (GHAA)	*Order Department* 1129 20th Street, NW Suite 600 Washington, DC 20036 (202) 778-3200	Fax-on-Demand (202) 331-7487	*HMO Industry Profile*
Interstudy Publications	*Order Department* 2901 Metro Drive, Fourth Floor Minneapolis, MN 55425 (612) 858-9291	Fax-on-Demand (612) 854-5698	*Competitive Edge Industry Report for HMOs*
American Medical Association (AMA)	*Order Department* 515 N. State Street Chicago, IL 60610 (800) 621-8335	Information-on-Request Fax Line (800) 621-8335	*Socioeconomics of the Medical Practice*
Medical Group Management Association	*Order Department* Denver, CO 80256-0444 (303) 397-7888	Fax-on-Demand (800) FAX-4MED	*Cost Survey* *Academic Practice Management Survey*
Health Care Financial Management Association (HFMA)	*Order Department* Two Westbrook Corporate Center, Suite 700 Westchester, IL 60154 (202) 296-2920	Fax-on-Demand (800) 839-HFMA	*Health Care Financial Management (monthly publication)* Issue Analysis 98-1, *Compliance with Laws and Regulations for Health Care Organizations*

INFORMATION SOURCES (*continued*)

Organization	*General Information*	*Fax Services*	*Web Site Address/Electronic Bulletin Board*	*Recorded Announcements*
American Institute of Certified Public Accountants	*Order Department* Harborside Financial Center, 201 Plaza Three Jersey City, NJ 07311-3881 (888) 777-7077 Information about the AICPA's continuing education program is available through the AICPA Professional Development Team at (888) 777-7077, menu item 1.	*24 Hour Fax Hotline* (201) 938-3787	www.aicpa.org	
Financial Accounting Standards Board	*Order Department* P O Box 5116 Norwalk, CT 06856-5116 (203) 847-0700, ext. 10	*24 Hour Fax on Demand* (203) 847-0700, menu item 14	www.fasb.org	*Action Alert Telephone Line* (203) 847-0700 (ext. 444)

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